AMENDED IN ASSEMBLY APRIL 21, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1091

Introduced by Assembly Member Negrete McLeod
(Coauthors: Assembly Members Pavley and Yee)

February 20, 2003

An act to amend Sections 104190, 104191, ~~104192,~~ and 104193 of*, and to add Section 104195 to,* the Health and Safety Code, relating to disease prevention.

LEGISLATIVE COUNSEL'S DIGEST

AB 1091, as amended, Negrete McLeod. Lyme ~~Disease~~ *disease.*

Existing law establishes the Lyme Disease Advisory Committee in the State Department of Health Services, composed of specified members appointed by the Director of Health Services. Existing law requires the department and the committee to perform various functions and duties with respect to, among other things, the dissemination of information regarding Lyme disease to the public and the medical community.

This bill would revise the composition and duties of the Lyme Disease Advisory Committee. It would also revise the duties of the department with respect to Lyme disease prevention and data collection.

Existing regulatory law requires licensed physicians and health care providers to report cases of specified reportable diseases, including Lyme disease, within 7 calendar days of detection to a local health authority. Existing regulatory law also requires each local health

officer to report cases of specified reportable diseases to the State Department of Health Services on a weekly basis.

This bill would establish procedures for the direct reporting of Lyme disease to the department.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. *(a) The Legislature finds and declares all of the following:*

(1) The enactment of Senate Bill 1115 (Ch. 668, Stats. 1999) established the Lyme Disease Advisory Committee and an information program in order to publicize Lyme disease, a bacterial infection, and address this major and increasing public health hazard in California.

(2) The cardinal criterion for the designation of Lyme disease, or any other human infectious disease, is the diagnosis by a physician and surgeon or other licensed health care practitioner, including a dentist, podiatrist, or nurse practitioner, licensed for practice in California. The denial or disavowal by a nonphysician of a diagnosis made by a licensed physician and surgeon, or other health care practitioner by a nonphysician who has not examined the patient constitutes the unlicensed practice of medicine.

(3) Not all people who are bitten by a western black-legged tick or nymph, which are capable of carrying Lyme disease and other coinfections, realize that they have been bitten. The risk of infection from the nymph is even greater than from the adult tick in California. An actuarial study by the Lyme Disease Foundation, Inc., and the Society of Actuaries found that, of 503 physician-diagnosed Lyme disease patients, only 30 percent realized they had been bitten, and 55 percent did not report a rash. Dr. Joseph Burrascano, Jr., M.D., in "The New Lyme Disease Diagnostic Hints and Treatment Guidelines for Tick Borne Illnesses," (Fourteenth edition, 2002) reported that erythema migrans, the rash that is diagnostic of Lyme disease, was present in fewer than one-half of Lyme disease patients. People who develop this rash, which is an initial indicator of Lyme disease, should seek immediate antibiotic treatment while the rash is visible and a correct diagnosis can be made.

(4) Some doctors and insurers claim that there is no Lyme disease in California, certainly not in southern California, or that it is very rare. These are voices of ignorance, clearly contradicted by the continuing fact that Lyme disease is a prevalent and growing public health problem in California.

(5) Some doctors and insurers claim that if a month of antibiotic treatment fails to cure a patient, then the initial diagnosis of Lyme disease was incorrect. This belief is proven incorrect by numerous reports of persistent infection in spite of treatment in peer-reviewed scientific literature, including reports that indicate positive cultures from the brain, spleen, heart, eye, spinal fluid, lymph nodes, joints, and joint fluid. Other infectious diseases, such as syphilis, tuberculosis, and HIV/AIDS, require months of antibiotic treatment. Indeed, the recently approved treatment guidelines for tuberculosis are two antimicrobials for 18 months each.

(6) Some individuals affected by the advanced stages of Lyme disease have suffered irreparable damage to their health, careers, and family. Common symptoms can be musculoskeletal (joint inflammation, pain, and arthritis), cardiac (heart block, palpitations, and tachycardia), and neurologic (extreme fatigue, memory loss, inability to concentrate, and facial palsy). The neurologic symptoms are at times mistaken for multiple sclerosis or early Parkinson's disease. Many victims suffer permanent physical or mental damage, or both, as a result of misdiagnosis, ignorance of the disease, and lack of effective treatment. Lyme disease can be fatal.

(7) The key problems of undertreatment and misdiagnosis are in part due to the need for further scientific development and understanding of Lyme disease and also due to the need for current medical education about this infectious disease, which has some parallels to syphilis in its changing symptomatology. Lyme disease mimics many other diseases. It is called the second "Great Imitator" after syphilis. Thus, it can be difficult to diagnose. The infectious agent, Borrelia burgdorferi (Bb), is a spiral shaped bacterium (spirochete) like syphilis that can invade any organ in the body. Patients are often diagnosed with more familiar conditions, including chronic fatigue, fibromyalgia, and multiple sclerosis, for which there is no "cure," just palliative remedies. If untreated, Lyme disease invades multiple organs of the body

including the brain and nervous system, and victims become increasingly disabled over time. In later stages of the disease, if antibiotic therapy is terminated before active clinical symptoms have cleared, relapse is likely. Prolonged antibiotic treatment by oral, intramuscular, or intravenous means, may be necessary. The absence of positive laboratory proof is not conclusive proof of the absence of the disease.

(b) The Legislature finds and declares the following concerning the reporting of Lyme disease:

(1) According to United States Centers for Disease Control and Prevention (CDC) statistics, the reported number of Lyme disease cases reached a record level of 17,730 cases in 2001, an increase of 87 percent over the previous decade. The increase in reporting is a reflection of the improved reporting standards, the national application of those standards, increased awareness, and the increased incidence of Lyme disease. Lyme disease is now a reportable disease in all 50 states. The CDC states that Lyme disease accounts for more than 95 percent of vector-borne illness in the United States. Even so, the CDC believes that only one in 10 cases are actually reported. Stated otherwise, the CDC is saying that their surveillance criteria do not recognize or include 90 percent of Lyme disease patients.

(2) The CDC surveillance criteria are complex and multifaceted and, in part, outdated so their use by the department results in the denial of many reported Lyme disease cases. The CDC, however, has publicly advised that its surveillance criteria are not intended as a basis for clinical diagnosis, insurance reimbursement, or treatment guidelines. These CDC surveillance criteria seriously underrepresent the actual prevalence of Lyme disease. According to a recent Georgia survey of 1331 physicians, 710 were respondents who diagnosed 578 Lyme disease cases over the preceding 12 months, an amount of diagnoses that greatly exceeds the 434 cases reported by the CDC for Georgia over a 10-year period. (Boltri JM et al. Patterns of Lyme disease diagnosis and treatment by family physicians in a southeastern state. J Community Health 2002, Dec, 27. (6):395-402). These statistics again illustrate that the use of CDC criteria results in a gross underreporting of Lyme disease.

(3) It is the intent of the Legislature to recognize and require the reporting of diagnoses of Lyme disease by licensed physicians and

health care practitioners and of positive laboratory test results of Lyme disease to the department and that the department not be allowed to set them aside or deny them because of CDC surveillance criteria. The primary concern must be the clinical diagnosis, which is critical to the reality of patients' care.

(4) The International Lyme and Associated Diseases Society (ILADS) has issued a position paper highly critical of the CDC's criteria for diagnosing Lyme disease. Their two-tiered approach using an Elisa test, which is outdated and unreliable, and confirming positives by use of both Western blot tests (IgG and IgM), misses many patients since the CDC criteria require five of 10 bands to be positive but omit two of the critical bands. If two or more bands 23-25, 31, 34, 39, and 41 kDa are evident, then it is a positive measure of the presence of antibodies to borrelia burgdorferi (Bb), a spiral shaped bacteria that is the infectious cause of LD, and assures certainty of exposure to Bb.

(5) Lyme disease is laboratory reportable in Ohio, New York, Maine, Massachusetts, and Pennsylvania. Despite the fact that over 10 percent of the national population resides in California, new Lyme disease cases reported in California accounted for only one-half of 1 percent of the national total, indicative of very substantial underreporting and that the state reporting procedures and use of CDC criteria for Lyme disease are in need of revision. The Senate of Texas, in issuing its November 2000 report on the Prevalence of Tick Borne Illness noted that "the rate of occurrence of tick-borne illness in the United States has increased dramatically over the last few years. This growth is second only to AIDS/HIV among infectious diseases."

(6) Information on laboratory reporting was obtained from several states. Maryland saw "a jump in number of reported cases when (it) turned to laboratory reporting in 1996." Massachusetts has a centralized reporting system much of it electronic (automatic). The "number of cases increased significantly when (they) instituted laboratory and active surveillance." Minnesota also has a centralized case evaluation with 2,400 laboratory reports received.

(7) Section 2500(j) of Title 17 of the California Code of Regulations lists reportable communicable diseases, including Lyme disease. Failure to report within seven days of identification of Lyme disease is a misdemeanor. However, the department's

"Lyme Disease Case Report form 8470" is quite detailed and the experience of some physicians is that their reports of Lyme disease are often questioned or seldom recorded with the consequence that since these reports are sent to the department through the county health officer, then these county health records later have to be undone. The process has seriously discouraged physician reporting. The department should not be second guessing a physician's diagnosis.

(8) The sophistication of laboratory tests for the diagnosis of Lyme disease is improving but could benefit from further development and standardization. Some of the still commonly used tests, like Enzyme-Linked Immuno Sorbent Assay (ELISA), are now considered outdated, not standardized, and only marginally reliable due to insufficient sensitivity and frequency of false positives from other diseases. A 1997 study by Bakken LL et. al., proved that ELISA was woefully inadequate as a screening test and invalidated the two-step protocol. (Interlaboratory Comparison of Test results for Detection of Lyme disease by 516 participants in the Wisconsin State Laboratory of Hygiene/College of American Pathologists Proficiency Testing Program. J Clin. Micro 35:537-543). To perform sophisticated Lyme disease testing requires a state-of-the-art laboratory, such as the federal Clinical Laboratory Improvement Act (CLIA; 42 U.S.C. Sec. 263a and following) licensed laboratories, which provide services to patients in California, and public health service laboratories in California deemed by the department to meet comparable standards. It is estimated that collectively the total of positively lab-identified California Lyme disease patients could exceed 1,500 a year in contrast to the 92 cases recorded by the department in 2001 or the 1,191 cases recorded by the department over the decade.

(9) It is the intent of the Legislature in enacting this act that the reporting provisions of Section 2500 of Title 17 of the California Code of Regulations, which require specified laboratories to report certain communicable diseases, be expanded to include Lyme disease.

(c) It is the intent of the Legislature that accurate information on Lyme disease diagnosis and scientifically recognized laboratory tests be included in the curricula of all state medical, pharmacy, veterinary, and nursing schools and of all continuing

medical education courses for health care practitioners and school nurses.

SEC. 2. (a) The Legislature finds and declares the following concerning Lyme disease:

(1) Despite current efforts, Lyme disease remains a significant problem for numerous reasons, including insufficient awareness among practicing physicians of the varying symptoms, diagnostic tests, and treatment protocols that may be effective in the treatment of Lyme disease. Of the total number of Lyme disease cases reported nationwide, 25 percent of those cases are children under the age of 15 years.

(2) The Medical Board of California reports that, in October 2002, the number of licensed state resident physicians was 86,934 while the comparable number for osteopathic physicians was 2,115, a total of over 89,000 licensed physicians. If it is assumed that 25 percent of these licensed physicians are retired or otherwise not in active practice, then the total number of licensed practicing medical practitioners is around 66,750. Informally, Lyme disease patients have identified fewer than 50 California physicians who regularly diagnose Lyme disease and prescribe appropriately for it, less than one-tenth of 1 percent of the total number of licensed practicing physicians in the state. Thus, there is a very serious access problem to qualified medical care services for Lyme disease patients.

(3) The Western black-legged tick has been found in 55 of the 58 counties in California, but is most common in the humid coastal areas and on the western slope of the Sierra Nevada range, including areas in southern California. While the Western black-legged tick or nymph may carry and spread the infection of Lyme disease, it may also carry coinfections, such as Babesiosis or Ehrlichiosis, among others, which are also reportable diseases. A coinfection complicates the diagnosis and treatment of Lyme disease. Thus, while the risk of acquiring Lyme disease varies by geographic area of exposure, it is a substantial public health hazard throughout most of the state and particularly for those who must work in those areas that are endemic with Lyme disease or for those who camp or hike through them.

(4) Lyme-infected adult ticks or nymphs have been identified in 41 counties in California to date and cases of Lyme disease have now been reported from 54 counties. However, Mendocino

County is the only county in California that has had an ongoing assessment for Lyme disease risk to date. In one small rural community, 37 percent of the residents had definite or probable Lyme disease while 24 percent were seropositive.

~~(5) The key problems of undertreatment and misdiagnosis are in part due to the need for further scientific development and understanding of Lyme disease and also due to the need for current medical education about this infectious disease, which has some parallels to syphilis in its changing symptomatology. Lyme disease mimics many other diseases. It is called the second "Great Imitator" after syphilis. Thus, it can be difficult to diagnose. The infectious agent, Borrelia burgdorferi (Bb), is a spiral shaped bacterium (spirochete), like syphilis, that can invade any organ in the body. Patients are often diagnosed as having familiar conditions, including chronic fatigue, fibromyalgia, multiple sclerosis, for which there is no "cure," just palliative remedies, in place of Lyme disease. Left untreated, Lyme disease invades multiple organs of the body, including the brain and nervous system. Victims become increasingly disabled over time. Lyme disease can be fatal. In later stages of the disease, if antibiotic therapy is terminated before active clinical symptoms have cleared, relapse is likely. Prolonged antibiotic treatment by oral, intramuscular, or intravenous means may be necessary. The absence of positive laboratory proof is not conclusive proof of the absence of the disease.~~

~~(6) According to United States Centers for Disease Control and Prevention (CDC) statistics, the reported number of Lyme disease cases reached a record level of 17,730 cases in 2001, an increase of 87 percent over the previous decade. The increase in reporting is a reflection of the improved reporting standards, the national application of those standards, increased awareness, and the increased incidence of Lyme disease. Lyme disease is now a reportable disease in all 50 states. The CDC states that Lyme disease accounts for more than 95 percent of vector-borne illness in the United States. Even so, the CDC believes that only one in 10 cases is actually reported. Stated otherwise, the CDC is saying that their surveillance criteria do not recognize or include 90 percent of Lyme disease patients.~~

~~(7)~~

(5) It is the intent of the Legislature that accurate information on tick-borne illness be included in the curricula of all state medical, pharmacy, veterinary, and nursing schools, and of all continuing medical education courses for health care practitioners and school nurses. Physician education is the key to more accessible and better health care.

(b) The Legislature finds and declares all of the following with respect to the Lyme Disease Advisory Committee (LDAC):

~~(1) The enactment of Senate Bill 1115 (Ch. 668, Stats. 1999) established the LDAC and an information program in order to publicize Lyme disease, a bacterial infection, and address this major and increasing public health hazard in California.~~

~~(2) The creation of this committee gave encouragement to Lyme disease patients and their families and it has been broadly favored in the Lyme disease community.~~

~~(3) The statute specified that five member representatives would serve on the committee, but did not limit the committee to that number. There are currently 10 members on the LDAC who serve at the pleasure of the Director of the State Department of Health Services.~~

~~(4)~~

(1) While these members serve without compensation, the current law provides that members may be reimbursed for travel and necessary expenses incurred in the performance of their duties. Given the current shortfall in the State Budget, it is the intent of the Legislature to limit travel reimbursement to travel costs incurred to attend committee meetings, if essential for a member's attendance, but not to exceed $2500 per year through the year 2006.

~~(5)~~

(2) Since the creation of the LDAC is viewed as a valuable asset and forum by the Lyme disease community, it is the intent of the Legislature ~~to establish terms of office for members of the committee~~ to assure its continuity and provide added stability.

~~(6)~~

(3) For the committee to proceed in its formulation of constructive solutions to the debilitation caused by Lyme disease, it is essential that it be composed of individuals with the best scientific, professional, and patient expertise possible. Therefore, it is the intent of the Legislature ~~to set forth the expertise required~~

~~of committee members and~~ to require that only those meeting these *significant* levels of expertise may continue to serve on the committee, and all individuals who are appointed to fill vacancies must also possess the ~~specified~~ *required* expertise.

~~(7) Enacting differing expertise requirements concerning the~~

(4) Requiring committee members *to have differing areas of expertise* will assure a diversity of talent to address the public health problems of Lyme disease. To the extent feasible, a reasonable geographic diversity among members should be sought as well.

~~SEC. 2.~~

SEC. 3. Section 104190 of the Health and Safety Code is amended to read:

104190. As used in this article the following definitions apply:

(a) ''Disease'' means Lyme disease recognized by the presence of the spirochete (borrelia burgdorferi), a spiral-shaped bacterium, in the human body, or coinfection with tick-borne diseases, such as Babesiosis and Ehrlichiosis.

(b) *"Long-term antibiotic or antimicrobial therapy" means the administration of oral, intramuscular, or intravenous antibiotics for periods of greater than four weeks.*

(c) ''Lyme Disease Support Network'' means the groups organized through hospitals and volunteer organizations to counsel and provide support to those individuals who have contracted the disease.

~~SEC. 3.~~

SEC. 4. Section 104191 of the Health and Safety Code is amended to read:

104191. (a) There is hereby created in the department the Lyme Disease Advisory Committee composed of, but not limited to, the following nine members:

(1) One who is a member of the board of directors of the ~~Lyme Disease Resource Center. An alternative board member from the Lyme Disease Resource Center may attend in place of this member if the member is unable to attend due to illness.~~ *Lyme Disease Resource Center.*

(2) Three who are Lyme disease patients, with a preference for the following distribution:

(A) One from a Lyme disease support group who is the coordinator of a patient support group in northern California.

(B) One from a Lyme disease support group who is the coordinator of a patient support group in southern California.

(C) One who contracted Lyme disease as an occupational injury and who is covered by workers' compensation.

(3) Two ~~from the California Medical Association~~ who are practicing physicians who are knowledgeable of, and whose *ongoing* practice includes the treatment of, both early- and late-stage Lyme disease. These physicians shall be from different geographic areas of the state.

(4) One local health officer, preferably from a Lyme disease endemic county.

(5) One who is a university or research scientist, preferably one with acknowledged expertise of the entomology of the western black-legged tick.

(6) One who is a university immunology or research scientist, preferably one with acknowledged expertise in spirochetes and related infectious diseases.

(7) The department shall also designate a member of its Vector Borne Disease Section or administration *or Surveillance and Statistics Section or administration*, to serve ex officio on the LDAC.

(b) Members of the committee shall be appointed by the director. In making these appointments, the director shall consider recommendations forwarded by the Lyme Disease Resource Center.

(c) Members of the committee shall serve without compensation, but after January 1, 2006, may be reimbursed for travel and necessary expenses incurred in the performance of their duties on the committee. In the interim, annual travel expense reimbursement to all committee members may not exceed $2,500.

(d) The Lyme Disease Advisory Committee shall meet no less than three times a year and the committee may, from its own membership, elect its own chair *and elect its own secretary.*

(e) On an annual basis, the committee shall conduct an assessment of its membership and recommend any needed changes in composition to the director. The director shall make appointments to fill vacancies as they occur.

(f) ~~(1)~~ To facilitate a cohesive working relationship among committee members and provide added stability to the committee's composition, each current and new member meeting the specifications detailed in subdivision (a) shall be eligible to serve a three-year term on or after January 1, 2004.

~~(2) During the year commencing with January 1, 2006, the committee shall establish a rotational designation to begin January 1, 2007, for one-third of its membership to be replaced annually by new three-year term members appointed by the director to fill vacated positions.~~

~~(3) Of the three members designated by the committee to rotate commencing January 1, 2007, and in subsequent years, if one of those members is considered by the committee to have made an exceptional contribution to the committee's work, and he or she has expertise that is difficult to replace, the committee may request that the director reappoint that member to a new three-year term.~~

(g) In order to facilitate accomplishment of the committee's activities using existing resources of the department, the committee may consult with or advise department staff regarding the prioritization of Lyme disease-related work, or the division of Lyme disease-related work between the department and, on a volunteer basis, individual committee members.

(h) The meetings of the committee shall be publicly announced at least one month prior to a meeting, and all meetings shall be open to the public. *These meetings shall have a twofold purpose. The first purpose is to conduct the formal business of the committee and to consider new developments in the understanding of Lyme disease, its treatment, laboratory evaluation, and prevention measures and changes in the incidence of the disease in California. The second purpose is to provide a public forum in which Lyme patients may alert the committee to key problems in their access to treatment by physicians and other health care providers and to health care coverage.*

(i) In order to assure accurate minutes, both the formal part of the meeting and subsequent discussion with persons in the audience shall be recorded, and all substantive input shall be part of the minutes of the meeting. The minutes of each meeting shall be sent to all committee members for review and approval within six weeks of the meeting. *The final decision on what shall be included in the minutes shall be that of the committee.*

(j) On a voluntary basis, the committee may encourage the formation of a subgroup among its members to develop proposed solutions for a specific problem aspect of Lyme disease on the members' own time.

~~SEC. 4.~~

SEC. 5. Section 104193 of the Health and Safety Code is amended to read:

104193. The department shall do all of the following:

(a) Establish a Lyme disease information program that provides educational materials and information services on Lyme disease to the general public and the medical community. The Lyme disease information program shall provide information on all of the following:

(1) The disease in general, including its symptoms.

(2) Activities that increase one's risk of contracting the disease.

(3) If and when a safe and effective vaccine is developed, use of vaccines to prevent the disease.

(4) The ways to protect oneself from contracting the disease, including the use of protective clothing and tick repellents, such as an acaricide or pesticide sprayed on clothing before being worn. Protective clothing includes light-colored long pants and long sleeves.

(b) Provide detailed but broad and inclusive information regarding Lyme disease, its varied and common symptoms, and its treatment to physicians and surgeons and other health care providers, such as nurse practitioners, in affected areas, including information concerning the use of both oral and intravenous antibiotics, and other evidence-based effective treatments, as they are recognized and publicly available. The department may fulfill this requirement by providing the information to professional associations representing these providers. If the department provides the information to professional associations, the department shall request that these professional associations make the information available to association members who request the information.

(c) Identify those segments of the population that are especially at risk of contracting Lyme disease and may provide workshops, with detailed information on the disease in those areas or communities, considering recommendations for these workshops by the Lyme Disease Advisory Committee.

(d) Provide information to the Occupational Safety and Health Standards Board about risk factors for exposure to Lyme disease.

(e) With the recommendation of the Lyme Disease Advisory Committee, and to the extent that departmental resources allow, consider the potential of new diagnostic and treatment procedures that have scientific foundation, particularly those that may be effective for the later stages of Lyme disease.

(f) Given that Lyme disease and its coinfections are emerging diseases and are not yet fully understood, the department shall not adopt rigid diagnostic or treatment limitations.

(g) In collaboration with interested counties, communities, research scientists, *universities,* health care providers, or members of the Lyme Disease Advisory Committee, the committee shall encourage the conduct of *professional training or* research and ~~the funding of~~ *its funding by grants or other support to increase the professional competence of health care providers in the treatment of Lyme disease or increase* research to identify the risk of Lyme disease in counties or areas of California where Lyme disease is considered to be endemic.

(h) Encourage the use of integrated pest management to control and reduce tick populations.

SEC. 6. Section 104195 is added to the Health and Safety Code, to read:

104195. (a) Notwithstanding any other provision of law, Lyme disease shall be reportable by both state-licensed physicians and health care practitioners upon positive diagnosis, and shall also be laboratory reportable, based on positive test results. The department shall develop a two-tiered system of counting Lyme disease cases. The first tier shall be based upon CDC criteria and the second tier of reporting shall be centralized and involve an automated clinical system based on an unduplicated count of patients who have a positive laboratory report of Lyme disease for the year the count is submitted.

(b) The primary report and diagnosis of Lyme disease shall be by a state-licensed physician or health care provider. However, if the diagnosing provider has treated few Lyme patients and is not certain of the diagnosis, then the provider should seek a second opinion from a provider who is experienced in diagnosing lyme disease who has examined the patient or seek laboratory test confirmation. If Lyme disease is confirmed, the diagnosis shall be

fully reportable and any laboratory reports shall be submitted directly to the department's Surveillance and Statistics Section and shall be accepted and recorded by the department, as received. Reports of Lyme disease to the department can only be denied or challenged by a licensed practicing physician experienced in the treatment of Lyme disease who has examined the patient. This centralized clinical reporting system shall become effective when the department's new computer resources, now in pilot testing, are operational for reporting purposes. The computer resources are expected to reduce staff burden and enable a two-tiered reporting system.

(c) The Lyme Disease National Surveillance Case Definition (DHS form 8470 of 10/01) may be used for departmental research but shall not be cited or used by staff in any way to preclude the recognition and recording of a diagnosis by a physician or health care practitioner or laboratory evidence of Lyme disease.

(d) When the department has the capacity to receive and record the electronic reporting of Lyme disease and major coinfections by licensed physicians, other appropriate health care providers, and licensed laboratories, then this reporting shall be encouraged, to the extent feasible.

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